CASE REPORT

The Development of Posttraumatic Stress Disorder Following an Unusual Life Event: A Case Report

by RICHARD C. CHRISTENSEN, MD, MA

Dr. Christensen is Professor and Chief of Division of Public Psychiatry at the University of Florida College of Medicine-Gainesville, Gainsville, Florida.

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ADDRESS CORRESPONDENCE TO: Richard C. Christensen, MD, MA, 611 E. Adams St., Jacksonville, FL 32202; Phone (904) 394-8068; Email: rchris@ufl.edu

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ABSTRACT

Posttraumatic stress disorder is the only psychiatric disorder, according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, that requires a specific life-threatening event to have occurred prior to diagnosing the illness. The traumatic event is described as an experience of witnessing either the occurrence, or imminent threat, of serious injury or death. This case report describes the development of posttraumatic stress in a middle-aged man, with no prior psychiatric history, after he ingested part of a candy bar he later discovered to be infested with maggots. This case report adds to the literature supporting a broader diagnostic view of posttraumatic stress in the absence of life-threatening stressors.

INTRODUCTION

It can be argued that few psychiatric diagnoses have generated more controversy than posttraumatic stress disorder (PTSD), as reflected in successive revisions of the criteria from 1980 onward.[1,2] PTSD is the only psychiatric disorder, according to the *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (DSM-IV)*, that requires a specific life-threatening event to have occurred prior to diagnosing the illness.[3] The traumatic event is described as an experience of witnessing either the occurrence, or imminent threat of, serious injury or death.

However, recent research has raised the possibility that certain life events that are not immediately life-threatening may also give rise to PTSD if they lead to a reaction that is perceived as horrifying or cause a serious disruption to the person's view of him- or herself in the world.[4] This paper describes a case of PTSD that developed in a middle-aged man, with no prior psychiatric history, after he ingested part of a candy bar he later discovered to be infested with maggots. This unique case adds to the literature supporting a much broader view of PTSD developing from life events that are not immediately life threatening nor hold the potential for serious bodily injury, yet provoke in the person an intense reaction

that causes profound social and occupational impairment.

CASE REPORT

On initial presentation, Mr. P was a 47-year-old, unmarried man with no previous psychiatric history. He was seen in our psychiatric clinic upon referral from his primary care provider to whom he had reported complaints of "depression." On the initial evaluation in our clinic, he reported being depressed because he was unable to stop thinking about an event that had occurred nearly one year prior when he discovered maggots in his partially eaten candy bar. He believed he had ingested some of the maggots before realizing the candy bar was contaminated. Since that event, he reported an inability "to get the picture out of my mind."

Per his account, once he discovered the maggots in his candy bar, he immediately returned to the store to complain. However, he suspected the customer service people were laughing about the episode and were "grossed out" by the incident. Even though a full report was written that documented the finding of the maggots in the partially consumed candy bar, he found the experience to be humiliating. Upon checking with his primary care provider, he was reassured that he would suffer no serious or long-term health consequences if he had ingested several maggots. However, since the initial event, he noted that he had been plagued by intrusive images of the maggots, memories of swallowing part of the candy bar, and persistent flashbacks to the event, which involved intermittently "seeing" maggots in his food. This led him to carefully check any food before eating it, especially when the item was prepackaged. Moreover, he began to worry excessively that people from his church community were wondering to themselves if, "he's the person that ate that candy bar with maggots in it." Finally, he had been experiencing infrequent nightmares of the event and of people laughing at him, which had caused significant sleep disruption.

Several months after the event he began to develop a persistently sad mood, decreased appetite, initial insomnia, tearfulness, anergia, and anhedonia. He denied auditory hallucinations as well as suicidal ideations. Although his only pre-existing health condition was well-controlled hypertension, he was very concerned that his recent gastrointestinal complaints (constipation and acid reflux) were directly related to eating some of the maggots. His social functioning had been reduced to spending time mostly with his family, a narrow circle of friends, and going to church on Sundays. However, in nearly all social encounters he was frequently on edge due to concerns he was being scrutinized by others who had heard about what had happened to him. He was no longer driving his truck for a living due to his "depression" and was living with his aging mother. He denied all illicit drug or alcohol use. Upon evaluation in our clinic, Mr. P. was diagnosed with PTSD and major depression, moderate, single episode.

Over the next nine months, Mr. P was treated with a sequentially implemented and slowly titrated combination of psychotropic medications (fluoxetine, 40mg each day; mirtazapine, 30mg at night; and risperidone, 3mg at night) and intermittent psychotherapy. He was adherent to his medication regimen and reported improvement in his depressive symptoms, particularly with regard to mood, sleep, and energy. He began to coach a youth football team and started to date again. However, he continued to report a high degree of distress due to memories and images of the partially eaten candy bar, "flashbacks" to the event ("Sometimes I just think I'm right back there seeing those maggots in the candy bar."), and "seeing" maggots in his food. Even though he could tell himself that he knows they are not actually present, he would not be able to finish his meal. He still had concerns that others had learned about the traumatic event and would ridicule him for eating the candy bar.

During this nine month treatment period, Mr. P made several attempts to engage in psychotherapy, but found the sessions too difficult due to the anxiety engendered when discussing/describing the precipitating event. However, he just recently undertook therapy again, and the sessions have been timed to provide him maximum "recovery time" in order to enhance continuity and consistency. He has been making slow progress through the use of a trauma-based, cognitive behavioral psychotherapeutic approach to develop a greater acceptance and tolerance of his traumatic memories, which have profoundly impacted his social and occupational functioning.

DISCUSSION

This particular case is noteworthy for at least two reasons. First, it focuses attention on the current A1 diagnostic criterion for PTSD and adds to the controversy of its clinical utility in the accurate identification of the disorder.[5,6] In this particular case example, if a clinician was evaluating Mr. P, and attempting to strictly apply the DSM-IV criteria in a consistent fashion, he or she could not diagnose PTSD. Strictly speaking, there was no perceived or actual life-threatening event. Mr. P knew from the outset that the ingestion of the maggots was not life-threatening and had been reassured that he would suffer no serious physical harm. Nonetheless, the event evoked an intense reaction of revulsion and disgust on his part, exacerbated by his sense of being publicly humiliated. (Indeed, his personality characteristics of being introverted and avoidant in social situations may have made him more susceptible to developing a more exaggerated response to the initial

event.) Unfortunately, Mr. P. went on to develop symptoms of re-experiencing (e.g., distressing recollections, images, and dreams), avoidance (e.g., efforts to avoid persons and places that aroused recollections of the trauma), and hyperarousal (e.g., difficulty falling asleep, concentrating) that profoundly impaired his social and occupational functioning. Hence, this case report adds support to the growing body of literature that suggests non-life threatening events, or low magnitude stressors, might result in PTSD in certain susceptible individuals.[7] Although these life events (e.g., work situations, burglary without confrontation of a burglar) do not fulfill the *DSM-IV* A1 stressor criterion, they have been shown to give rise to PTSD symptoms in certain individuals.[3]

Second, this case is significant because a major depressive disorder developed after the emergence of PTSD and could have masked the underlying anxiety disorder. In fact, the PTSD was not identified by Mr. P's primary care provider, and it was the depressive symptomatology that resulted in the psychiatric referral. However, even though the two disorders were comorbid at the time of presentation in the psychiatry clinic, it was quite clear that the chronology of the depression developed several months after the PTSD symptoms emerged. According to recent literature, this describes a sequence of clinical events which is not uncommon.8,9 Over a nine month period after treatment had been initiated, Mr. P's depressive disorder improved. However, currently slow progress toward symptom resolution and restoration of functioning is underway with regard to the PTSD syndrome. Hence, clinicians should be mindful that even though there may be symptom overlap between the two disorders, each may require different treatment approaches in order to achieve full remission and recovery.

CONCLUSION

This case report can be viewed as lending support to the collective voice of those who are urging contributors developing the *DSM-V* to carefully reconsider what constitutes the type and duration of the life stressor(s) that can lead to PTSD.[10] Based upon cases similar to the one described here, one could argue that when considering the diagnosis of PTSD, less emphasis should be placed upon the precise severity of the stressors described under the A1 criterion provided criteria B (re-experiencing), C (avoidance), D (hyperarousal), and F (significant distress/functioning) have developed following the life event. Although current *DSM-IV* nosology requires the occurrence of a life-threatening event to secure the diagnosis of PTSD, it is imperative that clinicians remember that certain individuals (due to a complex mix of characterological, emotional, and cognitive resiliencies) may be traumatically impacted by events that are neither imminently life-threatening or hold the potential for serious bodily injury.

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